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Chief Executive Officer

July 21, 2011

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From: William T Fujioka
Chief Executive Officer

KATIE A. IMPLEMENTATION PLAN SEMI-ANNUAL UPDATE

On October 14, 2008, your Board approved the Katie A. Strategic Plan (Strategic Plan), a single comprehensive and overarching vision of the current and planned delivery of mental health services to children under the supervision and care of child welfare as well as those children at-risk of entering the child welfare system. The Strategic Plan provides a single roadmap for the Countywide implementation of an integrated child welfare and mental health system in fulfillment of the objectives identified in the Katie A. Settlement Agreement.

The Strategic Plan describes a set of overarching values and ongoing objectives, offers seven primary provisions to achieve these objectives, and lays out a timeline by which these strategies and objectives are to be completed. The seven primary provisions include:

KATIE A. STRATEGIC PLAN OBJECTIVES	
1. Mental Health Screening and Assessment	2. Mental Health Service Delivery
3. Funding of Services/Legislative Activities	4. Training
5. Caseload Reduction	6. Data and Tracking of Indicators
7. Exit Criteria and Formal Monitoring Plan	

Implementation Support Activities

DATE	DESCRIPTION
October 2010	The Department of Mental Health (DMH) has contracted with Exodus Urgent Care Center to provide urgent mental health services to DCFS children and youth ages 13 and above.
February 2011	DMH and Department of Children and Family Services (DCFS) have developed a protocol for responding to children with acute and urgent mental health needs. This protocol requires that services be initiated within no more than 24-hours for acute cases and three days for urgent cases. In addition, the mental health provider must prepare a timely written report to DCFS detailing the client's status, services provided and services planned.
April 2011	DMH and DCFS staff reviewed approximately 50 DCFS cases that have received a mental health screening. These cases were evaluated to determine fidelity to the Coordinated Services Action Team (CSAT) protocol and the appropriateness of the response.
May 2011	DMH was given the approval to hire eight additional positions to augment the Psychiatric Mobile Response Teams (PMRT) response to emergency calls involving DCFS children and youth. DCFS has also reassigned four positions to assist DMH with the coordination of emergency responses to DCFS children and youth.
May 2011	Enhanced Skill Based Training (ESBT) has been rolled out to 65 percent of Line Supervisors and 30 percent of Children's Social Workers (CSWs). In addition, all DMH Service Planning Area (SPA) 6 contracted mental health providers have been trained in the foundation of the Core Practice Model (CPM).
June 2011	To date, 78 cases have been randomly selected for Quality Service Review (QSR) from seven DCFS regional offices. Review findings are currently being utilized by local DCFS leaders and practice partners to support efforts to improve practice.

OBJECTIVE NO. 1
Mental Health Screening and Assessment

Medical Hubs

In Fiscal Year (FY) 2010-2011, approximately 70 percent of newly detained children received an Initial Medical Examination at a Medial Hub (Hubs). On February 22, 2011, the County implemented the Enterprise Medical Hub (E-mHub) system. The E-mHub system was developed to strengthen the continuity of care by the Department of Health

Services (DHS)-operated Hubs and to improve information sharing between DCFS and the Hubs. The E-mHub system is expected to significantly improve the percentage of priority population children served by the Hubs and will contribute to the reduction of the "no-show" rate. As part of a joint effort between DHS and DCFS, the E-mHub system accepts the electronic transmission of the DCFS Hub Referral form and returns the resulting appointment status to DCFS via e-mail notification to the currently assigned CSW, Supervising Children's Social Worker (SCSW), Public Health Nurse (PHN), PHN Supervisor and respective CSAT staff.

Coordinated Services Action Team - Redesign

The CSAT process requires expedited screening and response times based upon the urgency of a child's needs for mental health services. As a result of a January 2010 Board Motion and subsequent case review, the Child Welfare Mental Health Screening Tool (MHST), the CSAT Screening and Assessment Policy, and the related DMH practice guidelines were revised to ensure the timely screening for, referral to, and provision of mental health services according to acute, urgent, and routine mental health needs identified. All CSAT previously trained offices have been retrained and are now implementing the CSAT redesign. The CSAT redesign training and implementation will be complete in August 2011.

Multidisciplinary Assessment Team

In March 2011, 89 percent of all eligible newly detained children Countywide were referred to the Multidisciplinary Assessment Team (MAT). From April 2010 to March 2011, there were 5,092 MAT referrals and 3,616 MAT assessments completed.

Table 1: MAT Compliance	MAT Eligible	MAT Referred	Percent
SPA 1	49	20	41%
SPA 2	52	51	98%
SPA 3	61	61	100%
SPA 4	46	46	100%
SPA 5	7	7	100%
SPA 6	103	89	86%
SPA 7	65	64	98%
SPA 8	47	45	96%
Total number of DCFS MAT referrals:	**430**	**383**	**89%**

It is important to note that the low referral rate in SPA 1 is due to MAT Provider capacity. Currently, there are only four MAT Providers in SPA 1, where most other SPAs have 10 or more. Although several SPA 1 MAT agencies are having difficulty filling positions due to the shortage of eligible staff candidates in the area, when the shortage of MAT capacity is limited, the DMH Specialized Foster Care (SFC) staff is able to prepare a comprehensive mental health assessment.

In addition, the revised MAT Summary of Findings (SOF) report was modified to improve its quality and was released Countywide in March 2011. A total of six trainings were conducted to orient and train over 200 MAT providers and County staff to the new format. In addition, monthly consultation calls provide staff the opportunity to review cases and assist with the development of strength-based assessments that address underlying needs. The MAT protocol has also been revised to improve service linkage following the MAT SOF and to clarify the role of the MAT team in addressing placement needs.

From April 2010 through May 2011, DMH MAT Coordinators have completed a total of 397 MAT Quality Improvement (QI) Checklists and 213 MAT CSW Interview Surveys. Overall, 91 percent of the QI checklist eight domain ratings were positive and 86 percent of the MAT CSW Interview Surveys seven domain ratings were positive.

D-Rate

DMH and DCFS have begun to review the needs of D-Rate children and the mental health services offered to them in an effort to better identify the programmatic needs of this population and to make reforms to the D-Rate program that could offer a more defined place on the DCFS/DMH spectrum of care. After careful review, DCFS and DMH determined that the MAT SOF reports (performed within the prior 12 months) contain clinically relevant information needed to establish D-Rate eligibility and will now be integrated into the child's placement and treatment planning. Although this process has just begun and is not subject to formal procedural guidelines, this new practice appears to be more efficient, less costly and has subjected children to fewer assessments.

In addition, DCFS and DMH have met to discuss the enhanced coordination between Wraparound services and Treatment Foster Care (TFC) utilizing D-Rate certified foster parents and relative caregivers. Although these discussions are preliminary in nature, DCFS and DMH are exploring the increased level of intervention available to D-Rate children and the degree to which D-Rate caregivers are able to receive additional support and guidance from Wraparound providers cross-trained in the TFC model.

Team Decision-Making/Resource Management Process

DCFS has completed 4,880 Team Decision-Making (TDM) meetings from November 2010 through February 2011 - a 17 percent increase from the previous report. Additionally, DCFS has completed a total of 568 Resource Management Process (RMP) TDMs on 52 percent of youth entering a group home, 53 percent of youth replaced, and 45 percent of youth exiting a group home. This was an increase of 218 RMPs from the last report.

OBJECTIVE NO. 2
Mental Health Service Delivery

Specialized Foster Care

The DMH SFC co-located staffs respond to requests for consultation from CSWs, provide referral and linkages to community-based mental health providers, offer treatment services when necessary, and participate in the CSAT process in those offices where CSAT has rolled out. Currently, DMH has 178 co-located staff in 18 DCFS regional offices. In addition, DMH is working with its provider community to improve capacity and utilization of mental health services, particularly among those providers not fully utilizing their Early, Periodic, Screening, Diagnosis, and Treatment (EPSDT) contracts, now totaling 64. These contracts now provide for over $120 million of targeted mental health services for DCFS children, including Wraparound, TFC, and MAT. Over 40 percent of the children with a current DCFS open case are receiving mental health services. DMH Child Welfare Division staff and service area administrations continue to engage in a series of technical assistance site visits with each of the Katie A. providers to improve proper utilization of their contracts and maximize their ability to serve DCFS children.

Wraparound

As of April 30, 2011, 2,082 children have been enrolled in Tier II Wraparound, which is ahead of the projected target (1,775). Tier I enrollments (1,033) have increased due to the temporary suspension of the RMP enrollment requirement to Tier I and the implementation of the Residentially-Based Services (RBS) program.

The Wraparound program is also undergoing a major redesign process in preparation for the new contract in 2014. Five workgroups were created to address the different focus areas: Fiscal, Contracts, Program, Practice, and Quality Improvement/Assurance. The objective of these workgroups is to make Wraparound more efficient and incorporate lessons learned, new advances in the field, and feedback

from consumers and community stakeholders. In addition, the County continues to discuss the impact of the two-tiered case rate system for Wraparound Tier I - $4,184 (inclusive of placement) and Tier II - $1,250 (exclusive of placement). To address this issue, the fiscal redesign workgroup has begun looking to combine the two rates and to maximize the use of EPSDT to support Wraparound services. The workgroup members have conducted a cost analysis of Tier I to help inform the case rate discussion and the development of new Wraparound contracts. DMH has continued to increase mental health contracts to support the expansion of the Wraparound program and has now provided EPSDT funding to support 3,115 Wraparound slots.

Treatment Foster Care

The target population for TFC is for the most emotionally or behaviorally challenged youth in, or at risk of placement in, group homes or psychiatric facilities. TFC provides an alternative to group home care for these children by providing intensive in-home therapeutic and behavior management services in a foster home with a limit on the number of children placed in that home. Although TFC program placements and contracts have increased, program growth was slowed due to time consuming and costly requirements placed on foster parents. Potential foster homes were required to obtain approval for foster as well as adoptive care. As a result, DCFS executive management has now waived this requirement for all TFC foster parents and will begin the process for modifying existing contracts with the Board of Supervisors.

Table 2: TFC Placement and Capacity *(as of April 30, 2011)*

	No. of Placed Children	Certified Homes	Certified Home Vacancies	Inactive Homes	Upcoming Beds
Intensive Treatment Foster Care (ITFC)					
	36	46	6	7	13
Multidimensional Treatment Foster Care (MTFC)					
	21	36	6	9	0
Grand Total	***57***	***82***	***12***	***16***	***13***

Overall, a total of 125 youth have received TFC services. Sixty-eight youth have transitioned out of the program with half recidivating to a higher level of care and the remainder graduating to a lower level of care (i.e. home of parent, legal guardian, relative and/or foster home). The success of TFC is also evidenced by those youth who remain stable in their TFC placements as this is a successful step toward permanency, pro-social stability, and as a result, present the County with a significant annual fiscal savings.

In June 2011, DCFS and DMH TFC staff developed a workgroup to increase the delivery of intensive treatment services to DCFS-involved youth (particularly those youth in D-Rate homes). Since the target populations for the TFC, Wraparound and D-Rate programs share similar needs, behaviors and risk factors, the DCFS/DMH workgroup will explore ways of utilizing existing Wraparound and D-Rate resources to provide a more flexible array of therapeutic services for the TFC target population. In addition, this workgroup will review and analyze the differences between those youth who have recidivated versus those who graduated from the TFC program.

OBJECTIVE NO. 3
Funding of Services/Legislative Activities

The FY 2010-11 Katie A. budget closed with $16 million in net County cost savings. The savings are primarily due to vacant Wraparound slots. As done with prior year savings, Chief Executive Office (CEO) has rolled the FY 2010-11 savings into a Provisional Financial Uses to offset fiscal commitments in FY 2011-12 and FY 2012-13 in support of the incremental rollout of the Strategic Plan.

The County has been informed that the settlement negotiations with the State are concluding and that a proposed settlement has been reached. The Court has directed the Special Master to submit his report detailing the settlement recommendations by July 22, 2011. Future updates will be provided when available.

OBJECTIVE NO. 4
Training

DCFS and DMH have developed curricula that encompass training for CSWs, co-located DMH staff, and community mental health providers to "Enhance Practice Skills". ESBT offers an overview and rationale of the content as well as training towards Strengths-Needs Based Practice, Engagement, and Teaming. To date, ESBT has been rolled out to 65 percent of Line Supervisors and 30 percent of CSWs In addition, along with the Los Angeles Training Consortium, DCFS has implemented coaching for Emergency Response (ER) supervisors to reinforce the ESBT in all DCFS offices. In July 2011, the DCFS Executive Team will be provided coaching sessions to teach and reinforce a strength-based approach for working with staff and constituents and to bolster their support of their workers and supervisors' ongoing participation in ESBT and coaching.

In April 2011, DMH completed the first of a 2-day CPM training for the SPA 6 children's mental health providers. This four-module training uses a train-the-trainer approach and will be subsequently provided to mental health providers in the remaining service areas

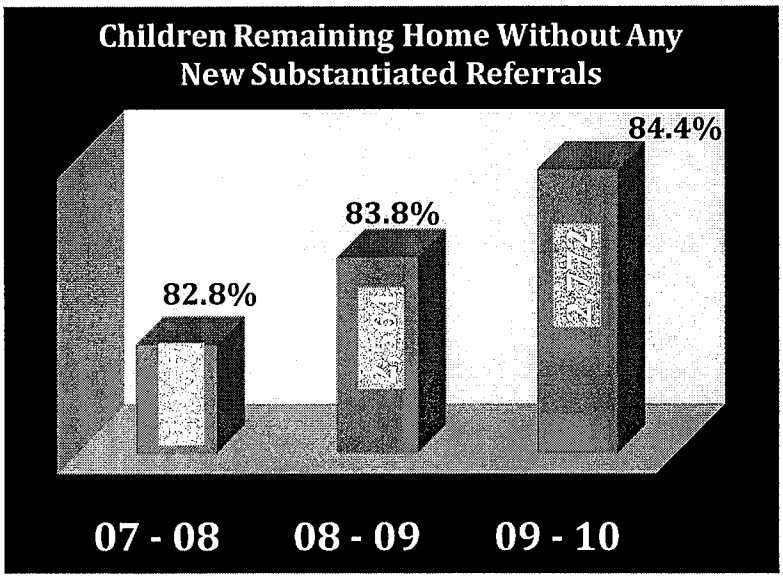
by September 2011. This classroom training will then be augmented by a series of coaching calls and meetings to support the implementation of the CPM. In addition, training has been provided to Specialized Foster Care, MAT and Wraparound providers in the key practice areas of: Cultural Competency, Needs-Based Assessment, Family Engagement, Dual Diagnosis, Crisis Management and mental health interventions with the birth to five population and their families.

OBJECTIVE NO. 5
Caseload Reduction

The DCFS total out-of-home caseload has been reduced from 15,650 (October 2010) to 15,429 (April 2011). Under the Title IV-E Child Welfare Waiver Capped Allocation Demonstration Project, this allows the Department to redirect dollars to much needed services to strengthen families and achieve safety, permanency, and well-being.

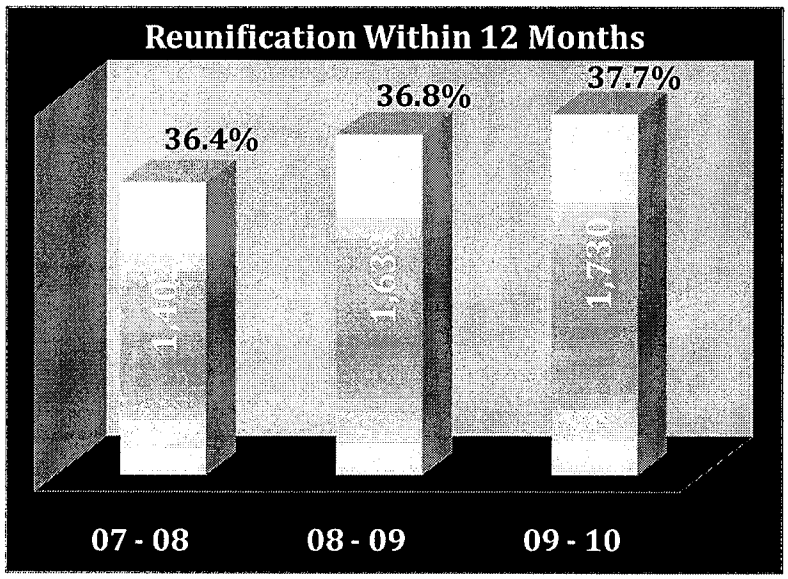
The individual CSW generic caseload average in April 2011 was 26.79, which is an increase of 1.82 children per social worker since October 2010 (24.97). The ER caseloads also depict a slight increase in number of referrals from October 2010 (17.10) to April 2011(17.5). These increased caseload averages reflect ongoing parallel ER over 60-day investigations. Both the generic and emergency response averages represent the seasonal fall and early spring Child Protection Hotline referral peaks. These peaks also generate an increase in Emergency Response Command Post follow-up referrals, increased workload related safety measures in emergency response activities/investigations and caseload averages.

OBJECTIVE NO. 6
Data and Tracking of Indicators



Safety Indicator 1:

Percent of cases where children remained home and did not experience any new incident of substantiated referral during case open period while receiving mental health services, up to 12 months.
The FY 09-10 (through March 2010) demonstrates that the majority of children are remaining safely at home.



Permanency Indicator 1:

Reunification within 12 months for children receiving mental health services.

Improvements in reunification are evident.

OBJECTIVE NO. 7
Exit Criteria and Formal Monitoring Plan

Quality Services Review

The Quality Service Review (QSR) provides an in-depth, case-based review of the front-line DCFS and system partners practice in specific locations and points in time. The QSR utilizes a combination of record reviews, interviews, observations, and deductions made from fact patterns gathered and interpreted by certified reviewers regarding children and families receiving services.

To date, 78 cases have been randomly selected for review. An average of nine children, youth, caregivers, family members, service providers and other professionals, per case, have been interviewed and the results have been fairly consistent across the seven DCFS regional offices reviewed – Belvedere, Santa Fe Springs, Compton, Vermont Corridor, Wateridge, Lancaster and Palmdale. On average, 86 percent of the cases across the offices are scored favorably on the Child and Family Status Indicators and roughly one-third of the cases scored favorably on the System Performance Indicators. Review findings are currently being utilized by local DCFS leaders and practice partners to stimulate and support efforts to improve practice.

The QSR schedule for 2011 includes: Pomona (July 11th), El Monte (August 22nd), Glendora (October 3rd), and Pasadena (November 14th). The remaining offices will be reviewed during the 2012 calendar year.

SUMMARY HIGHLIGHTS

DATE	DESCRIPTION
Ongoing	CPM, ESBT, Coaching and QSR training continues to roll out to both DCFS and DMH staff and providers to improve practice.
Ongoing	DMH and DCFS continue to enhance the implementation and coordination of the high-needs service delivery spectrum of TFC, Wraparound and D-Rate.
May 2011 – 1st Quarter 2012	Implementation planning is underway for the PMRT–Expedited Response Pilot, including hiring, development of DCFS policy and procedures, and tracking system.
July 2011	The County has been informed that the settlement negotiations with the State are concluding and that a proposed settlement has been reached. The Court has directed the Special Master to submit his report detailing the settlement recommendations by July 22, 2011.

Please let me know if you have any questions regarding the information contained in this report, or your staff may contact Kathy House, Assistant Chief Executive Officer, at (213) 974-4530, or via e-mail at khouse@ceo.lacounty.gov.

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